UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REBIF(interferon beta-1a)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** diagnosis of Multiple Sclerosis

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician or pharmacy

7/19/6